SECTION 12
PATIENT COST SHARING AND CO-PAY

Patients eligible to receive certain Missouri Medicaid services are required to pay a small portion of the cost of the services. This amount is referred to as cost sharing or co-pay. The cost sharing or co-pay amount is paid by the patient at the time services are rendered. Services of the Hospital Program described in this book may be subject to a cost sharing or co-pay amount. The provider must accept in full the amounts paid by the state agency plus any cost sharing or co-pay amount required of the patient.

PROVIDER RESPONSIBILITY TO COLLECT COST SHARING AMOUNTS

Providers of service must charge and collect the cost sharing amount. Providers of service may not deny or reduce services to persons otherwise eligible for benefits solely on the basis of the patient's inability to pay the fee when charged. A patient's inability to pay a required amount, as due and charged when a service is delivered, shall in no way extinguish the patient's liability to pay the amount due.

As a basis for determining whether an individual is able to pay the charge, the provider is permitted to accept, in the absence of evidence to the contrary, the patient's statement of inability to pay at the time the charge is imposed.

The provider of service must keep a record of cost sharing amounts collected and of the cost sharing amount due but uncollected because the patient did not make payment when the service was rendered.

The cost sharing amount must not be shown on the claim form. The cost sharing amount is deducted from the allowable amount, as applicable, before reimbursement is made.

PATIENT RESPONSIBILITY TO PAY COST SHARING AMOUNTS

Unless otherwise exempted (see following information), it is the patient's responsibility to pay the required cost sharing amount due. Whether or not the patient has the ability to pay the required cost sharing amount at the time the service is furnished, the amount is a legal debt and is due and payable to the provider of service. A patient is not required to pay both a co-pay and cost sharing amount. When a co-pay amount applies, a cost sharing amount is not charged to the patient.

COST SHARING AMOUNTS

The following cost sharing amounts are applied to services:

Inpatient Hospital	$10.00 per hospital stay (applicable on date of admission and charged to the patient prior to discharge)

Outpatient Clinic or Emergency Room	$2.00 for each date of service
Physician's Services (Outpatient or Emergency Room)	$1.00 for each date of service

EXEMPTIONS TO THE COST SHARING AMOUNT

The following patients or conditions are exemptions to the patient's responsibility for the cost sharing amount:

Patients

- Patients under Age 18;
- Foster care children up to 21 years of age; (ME codes 07 and 08);
- Hospice patients;
- Institutionalized patients who are residing in a skilled nursing facility, a psychiatric hospital, a residential care facility, or an adult boarding home;
- MC+ health plan enrollees are exempt from cost sharing amounts for services provided by the health plan.

Conditions

- Services related to an Early Periodic Screening, Diagnosis and Treatment (EPSDT/HCY) service. (V20.2 diagnosis or indicator);
  NOTE: The EPSDT/HCY exemption only applies to those patients under age 18. Patients age 18 and over are subject to the cost sharing amount for EPSDT related services unless another exemption applies.
- Emergency services; (Condition Code AJ and Admission Type 1 **must** shown on the claim form);
- Drugs and services specifically identified as relating to family planning services; (Drug class or family planning indicator);
- Services provided to pregnant women which are directly related to the pregnancy or a complication of the pregnancy; (Diagnosis code)
- Emergency inpatient admission (including newborn); (Admit type)
- Transfer inpatient admission; (Admit type)
- Therapy services in an emergency room or outpatient hospital setting: (physical therapy, chemotherapy, radiation therapy, psychology/counseling and renal dialysis) (Condition code AJ **must** be shown on the out patient claim.).

PROVIDER RESPONSIBILITY TO COLLECT CO-PAY AMOUNTS

Providers of service must charge and collect the co-pay amount. Providers of service may not deny or reduce services to persons otherwise eligible for benefits solely on the basis of the patient's inability to pay the fee when charged. A patient's inability to pay a

required amount, as due and charged when a service is delivered, shall in no way extinguish the patient's liability to pay the amount due.

As a basis for determining whether an individual is able to pay the charge, the provider is permitted to accept, in the absence of evidence to the contrary, the patient's statement of inability to pay at the time the charge is imposed.

The provider of service must keep a record of co-pay amounts collected and of the co-pay amount due but uncollected because the patient did not make payment when the service was rendered.

The co-pay amount is not to be shown as an amount received on the claim form submitted for payment. When determining the reimbursement amount, the co-pay amount is deducted from the Medicaid maximum allowable amount, as applicable, before reimbursement is made.

PATIENT RESPONSIBILITY TO PAY CO-PAY AMOUNTS

It is the responsibility of the patient to pay the required co-pay amount due. Whether or not the patient has the ability to pay the required co-pay amount at the time the service is furnished, the amount is a legal debt and is due and payable to the provider of service. The co-pay only applies to identified services and patients with certain medical eligibility codes.

INPATIENT SERVICES REQUIRING A CO-PAY

Individuals with an ME code of 76 must pay a $10.00 co-pay for inpatient services. The co-pay amount applies whether the individual receives services on a fee-for-service basis or is enrolled in a health plan. The co-pay amount is deducted from the Medicaid Maximum Allowable amount for fee-for-service claims reimbursed by the Division of Medical Services. Emergency and transfer admissions and newborn services do not require a co-pay.

OUTPATIENT CLINIC SERVICES REQUIRING A CO-PAY

Individuals with an ME code of “74” must pay a $5.00 co-pay and individuals with an ME code of 75 or 76 must pay a $10.00 co-pay for identified services. The following services require a co-pay.

Procedure Codes	
97001	Physical Therapy Evaluation
97002	Physical Therapy Re-evaluation
97003EP*	Occupational Therapy Evaluation
97004EP*	Occupational Therapy Re-evaluation
92506EP*	Speech Therapy Evaluation

* NOTE: persons eligible with an ME code of 76 are not eligible to receive services under these procedure codes as these are EPSDT/HCY services

and are non-covered for low-income uninsured parents even if they are under the age of 21.

Revenue Codes

0510	Non-surgical facility charge
0490	Surgical facility charge
0450	ER-Non-surgical facility charge
0459	ER-Surgical facility charge

A facility charge cannot be billed the same day as an evaluation. Only one co-pay applies per date of service.